PATRIOT Healthcare

MEMBER EXPENSE SUMMARY

THIS FORM MUST BE SUBMITTED WITHIN 90 DAYS OF A NEW GROUP'S COVERAGE EFFECTIVE DATE WITH DOCUMENTATION SUCH AS EOB AND/OR RECEIPTS TO THE ADDRESS BELOW.

New Hires and Re-hires are not eligible for these credits.

Patriot Healthcare
PO Box 2000
Exeter, NH 03833-2000

*Employee ID:*_____
*Employee Name:*_____
*Employer Name:*_____
Previous Health Insurance Carrier Name and Plan:
_____

The following costs are being submitted for consideration as credit towards my plan deductible. The below history reflects costs for me and/or my family for copayments, coinsurance, and/or deductibles AND were not covered/reimbursed by insurance previously active during this calendar year.

IMPORTANT: *For* ***Patriot Standard Plan Members****, we will only credit prior inpatient/outpatient expenses. We will not credit copayments for office visits or prescription drugs.*

Date of Service/Rx	Explanation of Service/Rx	$ Member paid—out of pocket	Name and DOB
		Total $	

_____
Date *Employee Signature*

Form 026b [10/2006]